Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
VISTA MEDICAL CENTER HOSPITAL

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-03-1595-02

Carrier's Austin Representative
Box Number 01

MFDR Date Received
NOVEMBER 21, 2002

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…if the total audited charges *for the entire admission* are at or above $40,000, the Carrier shall reimburse using the 'Stop-Loss' Reimbursement Factor' (SLRF). The SLRF of 75% is applied to the 'entire admission.'"

Requestor's Supplemental Position Summary Dated July 29, 2014: "Please allow this letter to serve as a supplemental statement to Vista Medical Center Hospital's (VMCH) originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeals' Final Judgment."

Amount in Dispute: $33,742.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated November 21, 2002: "The bill and documentation attached to the dispute have been carefully re-reviewed and our position remains the same…Only the hardware removal and foraminotomy was authorized. The provider performed much more extensive surgery than was authorized. Liberty Mutual was not notified of the additional procedures performed and they were not authorized…All items pertaining to the unauthorized surgical procedures were denied as not authorized…Liberty Mutual does not believe that Vista Medical Center Hospital is due any further reimbursement."

Response Submitted by: Liberty Mutual Insurance

Respondent's Supplemental Position Summary Dated August 1, 2014: "Because Requestor has failed to meet its burden of demonstrating the existence of both unusually extensive *and* unusually costly services, and the documentation adduced thus far fails to provide any rationale which might justify the Requestor's qualification for payment under the Stop-Loss Exception, Respondent's payment was appropriate. No additional monies are due."

Responses Submitted by: Hanna & Plaut, L.L.P.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 26, 2001 through November 30, 2001	Outpatient and Inpatient Hospital Services	$33,742.53	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 and §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, 22 *Texas Register* 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F-Reduction according to fee guidelines.
   - M-Reduced to fair and reasonable.
   - Z585-The charge for this procedure exceeds the health facility fee schedule assigned by the Texas Workers Compensation Commission.
   - Z695-The charges for this hospitalization have been reduced based on the fee schedule allowance.
   - Z601-The charge exceeds usual and customary..
   - Z652-Recommendation of payment has been based on a procedure code which best describes services rendered.
6. Dispute M4-03-1595-01 History
   - Dispute was originally decided on July 15, 2004.
   - The original dispute decision was appealed to District Court.
   - District Court remanded the dispute to the Division pursuant to an agreed order of remand, cause number D-1-GN-07-003718 dated January, 2012.
   - Because of the remand order, the dispute was re-docketed at the Division's medical fee dispute resolution section.
   - M4-03-1595-02 is hereby reviewed

Issues

1. Did the respondent provide sufficient explanation for denial of the disputed services?
2. Was the response submitted in accordance with former 28 Texas Administrative Code §133.307?
3. Did the audited charges exceed $40,000.00?
4. Did the admission in dispute involve unusually extensive services?
5. Did the admission in dispute involve unusually costly services?
6. Is the requestor entitled to additional reimbursement?

Findings

This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that "to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed $40,000 and that an admission involved unusually costly and unusually extensive services." Both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The division received supplemental information as noted in the position summaries above. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Third Court of Appeals' November 13, 2008 opinion, the division will address whether the total audited charges ***in this case*** exceed $40,000; whether the admission and disputed services ***in this case*** are unusually extensive; and whether the admission and disputed services ***in this case*** are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part, that "Independent reimbursement is allowed on a case-by-case

basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection…" 28 Texas Administrative Code §134.401(c)(6) puts forth the requirements to meet the three factors that will be discussed.

1. The requestor in its position statement asserts that "The only payment exception codes utilized by the Carrier in this instance were 'F'." 28 Texas Administrative Code §133.304(c), 17 Texas Register 1105, effective February 20, 1992, applicable to dates of service in dispute, states, in pertinent part, that "At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission's instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier's action(s). A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section."

   The payment exception codes and descriptions listed above in the background section support an explanation for the reduction of reimbursement based on former 28 Texas Administrative Code §134.401, and were provided using the appropriate division-approved form TWCC 62. These reasons support a reduction of the reimbursement amount from the requested stop-loss exception payment reimbursement methodology to the standard per diem methodology amount and provided sufficient explanation to allow the provider to understand the reason(s) for the insurance carrier's action(s). The division therefore concludes that the insurance carrier has substantially met the requirements of 28 Texas Administrative Code §133.304(c).

2. Former 28 Texas Administrative Code §133.307(j)(2)states "The response shall address only those denial reasons presented to the requestor prior to the date the initial request for medical dispute resolution was filed with the division and the other party. Responses shall not address new or additional denial reasons or defenses after the filing of an initial request. Any new denial reasons or defenses raised shall not be considered in the review."

   The respondent raises the issue of preauthorization, personal convenience items, unrelated to compensable injury in the November 21, 2002 response to the request for dispute resolution. A review of the submitted explanation of benefits finds that these issues were not raised as a basis for denial of payment. The respondent did not submit any documentation to support that these denial reasons were raised prior to the requestor seeking dispute resolution. In accordance with former 28 Texas Administrative Code §133.307(j)(2), the issue of preauthorization, personal convenience items, unrelated to compensable injury will not be considered further in this review.

3. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states "…to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed $40,000, the minimum stop-loss threshold." Furthermore, (A) (v) of that same section states "…Audited charges are those charges which remain after a bill review by the insurance carrier has been performed…" Review of the explanation of benefits issued by the carrier finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v); therefore the audited charges equal $102,939.43. The Division concludes that the total audited charges exceed $40,000.

4. The requestor in its original position statement asserts that "if the total audited charges *for the entire admission* are at or above $40,000, the Carrier shall reimburse using the 'Stop-Loss' Reimbursement Factor' (SLRF). The SLRF of 75% is applied to the 'entire admission'." As noted above, the Third Court of Appeals' November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 *South Western Reporter Third* 538, 550 (Texas Appeals – Austin 2008, petition denied) rendered judgment to the contrary. The requestor's original assertion is not supported.

   In its supplemental position statement, the requestor considered the Courts' final judgment and opined on both rule requirements. In regards to whether the services were unusually extensive, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. Rule §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that "This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission." The requestor's supplemental position statement asserts that:

   > The medical records on file with MDR show this admission to be a complex lumbar fusion. This complex spine surgery is unusually extensive for at least the following reasons:
   >
   > - This type of surgery is unusually extensive when compared to all surgeries performed on workers' compensation patients in that only 19% of such surgeries involved operations on the spine;

- This type of surgery required a physician for neuromonitoring, a cell saver, additional, trained nursing staff and specialized equipment thereby making the hospital services unusually extensive;

- This patient had significant blood loss requiring a blood transfusion of 2 units; he had difficulty breathing requiring breathing treatments and developed confusion.

- Medicare length of stay for this DRG is 3.7 days and the median length of stay for workers' compensation inpatient admissions is three days, whereas the length of stay for this admission exceeds both the Medicare LOS and the median LOS for workers' compensation.

The requestor's categorization of spinal surgeries presupposes that all spinal surgeries are unusually extensive for the specified reasons. The requestor did not submit documentation to support the reasons asserted, nor did the requestor point to any sources for the information presented. The reasons stated are therefore not demonstrated. Additionally, the requestor's position that all spinal surgeries are unusually extensive does not satisfy §134.401(c)(2)(C) which requires application of the stop-loss exception on a case-by-case basis. The Third Court of Appeals' November 13, 2008 opinion affirmed this, stating "The rule further states that independent reimbursement under the Stop-Loss Exception will be 'allowed on a case-by-case basis.' *Id.* §134.401(c)(2)(C). This language suggests that the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases." The requestor's position that this type of surgery was unusually extensive fails to meet the requirements of §134.401(c)(2)(C) because the requestor does not demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgeries, services or admissions. For the reasons stated, the division finds that the requestor failed to demonstrate that the services in dispute were unusually extensive.

5. In regards to whether the services were unusually costly, the Third Court of Appeals' November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 28 Texas Administrative Code §134.401(c)(6) states that "Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker." The requestor's supplemental position statement asserts that:

   The medical and billing records on file with MDR also show that this admission was unusually costly for the following reasons:
   - The median charge for all workers' compensation inpatient surgeries is $23,187; the median charge for workers' compensation surgeries of this type is $39,000; therefore, the audited billed charges for this surgery substantially exceed not only the median charges, but also the $40,000 stop-loss threshold;
   - As mentioned in the preceding paragraph, in order for this surgery to be performed, specialized equipment such as large bore IV's and an arterial line and specially trained, extra nursing staff were required, thereby adding substantially to the cost of the surgery in comparison to other types of surgeries; and
   - It was necessary to purchase expensive implants for use in the surgery.

   Therefore, additional reimbursement should be ordered under the stop-loss exception.

   The requestor asserts that because the ***billed charges*** exceed the stop-loss threshold, the admission in this case is unusually costly. The requestor overlooks the fact that within the Texas Labor Code, total billed charges are not a valid indicator of cost as explained in the preamble to 28 Texas Administrative Code §134.401, 22 Texas Register 6246, effective August 1, 1997. Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The Division notes that audited charges are addressed as a separate and distinct factor described in 28 Texas Administrative Code §134.401(c)(6)(A)(i). The requestor fails to demonstrate that the ***costs*** associated with the services in dispute are unusual when compared to similar spinal surgery services or admissions. For that reason, the division rejects the requestor's position that the admission is unusually costly based on the mere fact that the billed or audited charges "substantially" exceed $40,000. The requestor additionally asserts that certain resources that are used for the types of surgeries associated with the admission in dispute (i.e. specialized equipment and specially-trained, extra nursing staff) added substantially to the cost of the admission. The requestor in this case does not list or quantify the costs associated with these resources in relation to the disputed services, nor does the requestor provide documentation make a reasonable comparison between the resources required for this admission and those required for similar spinal surgeries, services or admissions. Therefore, the requestor fails to demonstrate that the resources used in this particular admission are unusually costly when compared to similar spinal surgeries, services or admissions.

6. For the reasons stated above the services in dispute are not eligible for the stop-loss method of

reimbursement. Consequently, reimbursement shall be calculated pursuant to 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount* and §134.401(c)(4) titled *Additional Reimbursements.* The Division notes that additional reimbursements under §134.401(c)(4) apply only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section.

- Review of the submitted documentation finds that the requestor billed $1,629.91 for date of service November 26, 2001 on an outpatient hospital bill; and $101,309.52 for dates of service November 27, 2001 through November 30, 2001 on an inpatient hospital bill. 28 Texas Administrative Code §134.401(b)(1)(B) states "Inpatient Services – Health care, as defined by the Texas Labor Code §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital." The requestor did not submit documentation to support a break in treatment to support billing date of service November 26, 2001 as an outpatient hospital stay. In addition, the requestor's request for reconsideration of payment requests stop loss reimbursement for dates of service November 26 through November 30, 2001; therefore, the Division finds that this inpatient hospitalization commenced on November 26, 2001 and ended on November 30, 2001.
- Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of $1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that "The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission…" The length of stay was four days. The surgical per diem rate of $1,118.00 multiplied by the length of stay of four days results in an allowable amount of $4,472.00.
- 28 Texas Administrative Code §134.401(c)(4)(A), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274)."
- A review of the submitted medical bill indicates that the requestor billed revenue code 278 for Implants at $36,980.00.
- Review of the medical documentation provided finds that although the requestor billed items under revenue code 278, no invoices were found to support the cost of the implantables billed. For that reason, no additional reimbursement can be recommended.
- 28 Texas Administrative Code §134.401(c)(4)(B) allows that "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399)." A review of the submitted hospital bill finds that the requestor billed $260.00 for revenue code 391-Blood Administration. 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the requestor does not demonstrate or justify that the amount sought for revenue code 391 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.

The division concludes that the total allowable for this admission is $4,472.00. The respondent issued payment in the amount of $43,777.84. Based upon the documentation submitted, no additional reimbursement can be recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed $40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually extensive services, and failed to demonstrate that the services in dispute were unusually costly. Consequently, 28 Texas Administrative Code §134.401(c)(1) titled *Standard Per Diem Amount,* and §134.401(c)(4) titled *Additional Reimbursements* are applied and result in no additional reimbursement.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		08/25/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.